

RESPIRATORY PROGRAM MEDICAL SURVEY

NOTICE: Wearing any type of respirator imposes some stress on the wearer. A person's ability to wear a respirator may be affected by medical limitations. For example, if an employee's cardiovascular or pulmonary function is impaired, wearing a respirator may pose a significant health risk. The purpose of this form is to identify employees who may have a medical ailment which requires additional consideration. Employees are urged to provide any additional medical information which they feel may affect their ability to wear a respirator.

Medical evaluation requirements for respirator users are specified in section 1910.139, Respiratory Protection, established by the Occupational Safety and Health Administration (OSHA). The questions on this form are from Appendix C, OSHA Respiratory Medical Evaluation Questionnaire, and are mandatory.

Your employer must allow you to complete this questionnaire during normal working hours, or at a time and place that is convenient to you.

The employee must complete Part A of this survey form. Part B is optional and should be completed if requested by a physician. After reviewing the completed form, a physician or licensed health care professional must complete Part C. Any additional information, obtained through questioning or physical examination, is up to the discretion of the reviewing physician or licensed health care professional. The employee and supervisor must sign Part D.

PART A (MANDATORY)

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Date: _____
 Employee's name: _____ Employee's Soc. Sec. Number: _____
 Employee's Age: _____ Employee's Weight: _____ Sex (circle one): Male/Female
 Position Title: _____ Employee's Duty Station: _____
 Supervisor's Name: _____ Supervisor's Title: _____

Check the type of respirator you will use (you can check more than one):

- a: _____ N, R, or P disposable respirator (filter mask, non-cartridge type only).
 b: _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Section 2. Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (check "yes" or "no").

	YES	NO
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?.....	_____	_____
2. Do you have or have you ever been treated for any of the following conditions:		
Seizures (fits).....	_____	_____
Diabetes.....	_____	_____
Allergic Reactions That Interfere With Your Breathing.....	_____	_____
Claustrophobia (fear of closed-in spaces).....	_____	_____
3. Have you ever had any of the following pulmonary or lung problems:		
Emphysema.....	_____	_____
Chronic Bronchitis.....	_____	_____

Part A, Section 2. Continued

YES NO

Asthma.....	_____	_____
Chronic Pulmonary Disease.....	_____	_____
Pulmonary Fibrosis.....	_____	_____
Tuberculosis.....	_____	_____
Collapsed Lung (Pneumothorax).....	_____	_____
Silicosis.....	_____	_____
Asbestosis.....	_____	_____
Coal Workers (Pneumoconiosis).....	_____	_____
Berylliosis.....	_____	_____
Lung Cancer.....	_____	_____
Broken Ribs.....	_____	_____
Any chest injuries or surgeries.....	_____	_____
Any other lung problems that you've been told about.....	_____	_____

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

Shortness of breath.....	_____	_____
Shortness of breath when walking fast on level ground or walking up a slight hill or incline.....	_____	_____
Shortness of breath when walking with other people at an ordinary pace on level ground.....	_____	_____
Have to stop for breath when walking at your own pace on level ground.....	_____	_____
Shortness of breath when washing or dressing yourself.....	_____	_____
Shortness of breath that interferes with your job.....	_____	_____
Coughing that produces phlegm (thick sputum).....	_____	_____
Coughing that wakes you early in the morning.....	_____	_____
Coughing that occurs mostly when you are lying down.....	_____	_____
Coughing up blood in the last month.....	_____	_____
Wheezing.....	_____	_____
Wheezing that interferes with your job.....	_____	_____
Chest pain when you breathe deeply.....	_____	_____
Any other symptoms that you think may be related to lung problems.....	_____	_____

5. Have you ever had any of the following cardiovascular or heart problems:

Heart attack.....	_____	_____
Stroke.....	_____	_____
Angina.....	_____	_____
Heart failure.....	_____	_____
Swelling in your legs or feet (not caused by walking).....	_____	_____
Heart arrhythmia (heart beating irregularly).....	_____	_____
High blood pressure.....	_____	_____
Any other heart problem that you've been told about.....	_____	_____

6. Have you ever had any of the following cardiovascular or heart symptoms:

Frequent pain or tightness in your chest.....	_____	_____
Pain or tightness in your chest during physical activity.....	_____	_____
Pain or tightness in your chest that interferes with your job.....	_____	_____
In the past two years, have you noticed your heart skipping or missing a beat.....	_____	_____
Heartburn or indigestion that is not related to eating.....	_____	_____
Any other symptoms that you think may be related to heart or circulation problems.....	_____	_____

7. Do you currently take medication for any of the following problems:

Breathing or lung problems.....	_____	_____
Heart trouble.....	_____	_____
Blood pressure.....	_____	_____
Seizures (fits).....	_____	_____

Part A, Section 2. Continued

YES NO

8. If you've used a respirator, have you ever had any of the following problems:
(If you've never used a respirator, go to question 9)

Eye irritation.....
Skin allergies or rashes.....
Anxiety.....
General weakness or fatigue.....
Any other problem that interferes with your use of a respirator.....

Questions 9 to 14 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA).

9. Have you ever lost vision in either eye (temporarily or permanently)?.....

10. Do you currently have any of the following vision problems:

Wear contact lenses.....
Wear glasses.....
Color blind.....
Any other eye or vision problem.....

11. Have you ever had an injury to your ears, including a broken ear drum?.....

12. Do you currently have any of the following hearing problems:

Difficulty hearing.....
Wear a hearing aid.....
Any other hearing or ear problem.....

13. Have you ever had a back injury?.....

14. Do you currently have any of the following musculoskeletal problems:

Weakness in any of your arms, hands, legs, or feet.....
Back pain.....
Difficulty fully moving your arms and legs.....
Pain or stiffness when you lean forward or backward at the waist.....
Difficulty fully moving your head up or down.....
Difficulty fully moving your head side to side.....
Difficulty bending at your knees.....
Difficulty squatting to the ground.....
Climbing a flight of stairs or a ladder carrying more than 25 lbs.....
Any other muscle or skeletal problem that interferes with using a respirator.....

PART B
(OPTIONAL)

Answers to the following questions, or other questions not listed, may be requested at the discretion of your physician.

YES NO

1. In your present job, are you working at high altitudes (5,000 feet) or in a place that has lower than normal amounts of oxygen:.....

If ``yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions:.....

Part B. Continued

YES NO

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals:.....

If ``yes," list them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- a. Asbestos:.....
- b. Silica (e.g., in sandblasting):.....
- c. Tungsten/cobalt (e.g., grinding or welding this material):.....
- d. Beryllium:.....
- e. Aluminum:.....
- f. Coal (for example, mining):.....
- g. Iron:.....
- h. Tin:.....
- i. Dusty environments:.....
- j. Any other hazardous exposures:.....

If ``yes," describe these exposures:_____

4. List any second jobs or side businesses you have:_____

5. List your previous occupations:_____

6. List your current and previous hobbies:_____

7. Have you been in the military services:.....

If ``yes," were you exposed to biological or chemical agents (either in training or combat):....

8. Have you ever worked on a HAZMAT team:.....

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications):.....

If ``yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s):

- a. HEPA Filters:.....
- b. Canisters (for example, gas masks):.....
- c. Cartridges:.....

Part B. Continued

	YES	NO
11. How often are you expected to use the respirator(s) (circle yes or no for all answers that apply to you):		
a. Escape only (no rescue):.....	_____	_____
b. Emergency rescue only:.....	_____	_____
c. Less than 5 hours per week:.....	_____	_____
d. Less than 2 hours per day:.....	_____	_____
e. 2 to 4 hours per day:.....	_____	_____
f. Over 4 hours per day:.....	_____	_____
12. During the period you are using the respirator(s), is your work effort:		
a. Light (less than 200 kcal per hour):.....	_____	_____
If ``yes," how long does this period last during the average shift: _____hrs. _____mins.		
Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.		
b. Moderate (200 to 350 kcal per hour):.....	_____	_____
If ``yes," how long does this period last during the average shift: _____hrs. _____mins.		
Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.		
c. Heavy (above 350 kcal per hour):.....	_____	_____
If ``yes," how long does this period last during the average shift: _____hrs. _____mins.		
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).		
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator:.....	_____	_____
If ``yes," describe this protective clothing and/or equipment:_____		
14. Will you be working under hot conditions (temperature exceeding 77 deg. F):.....	_____	_____
15. Will you be working under humid conditions:.....	_____	_____
16. Describe the work you'll be doing while you're using your respirator(s):_____		
17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):_____		

Part B. Continued

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
Name of the second toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
Name of the third toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
The name of any other toxic substances that you'll be exposed to while using your respirator: _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): _____

PART C

(MANDATORY)

TO BE COMPLETED BY PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL

The employee is approved to wear the respirators identified in Part A, Section 1 of this survey:

Physician's Signature

The employee in **not** approved to wear the respirators identified in Part A, Section 1 of this survey

Physician's Signature

Physician's Comments (Please include any other considerations, such as limitations on respirator use associated with medical conditions, the need for follow-up evaluations, etc.): _____

Physician's Name: _____
Physician's Address: _____

PART D

(MANDATORY)

Employee Signature: _____ Date: _____

Supervisor: _____ Date: _____

Forward a copy of this form, and any additional medical documentation to:

USDA, APHIS
Field Servicing Office
Butler Square, 5th Floor
100 N. 6th Street
Minneapolis, MN 55403ATTN:

Human Resources Operations, File